STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING _____ B. WING _____	R 01/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on December 10, 2014.

Survey dates: January 14, 15 and 16, 2015

Facility number: 000039
Provider number: 155685
AIM number: 100275130

Survey team:
Lora Swanson, RN-TC
Sharon Ewing, RN
Deb Kammeyer, RN
Julie Wagoner, RN

Census bed type:
SNF/NF: 158
Total: 158

Census payor type:
Medicare: 15
Medicaid: 111
Other: 32
Total: 158

Golden Living Center-Elkhart was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Recertification and State Licensure Survey.

Quality Review completed on January 21, 2015, by Brenda Meredith, R.N.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE